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ABSTRACT

Research indicates that families that adopt have many problems that would have existed even if the adopted child had been a biological member of the family, but that become more complex and intense due to adoption. A psychosocial and psychodynamic perspective toward family life suggests that in the adoption process, child and family pass through predictable phases that coincide with family and individual development. These phases are: (1) pre-awareness of the adoptive status; (2) dim awareness of a special state; (3) cognitive integration of biological and social differences; (4) personal and identity crisis of the adopted adolescent; and (5) concomitant acceptance of the biological and adoptive family. Compared to younger adoptees, those who are older pass through a similar set of phases, but move through the first two more rapidly because of their broader intellectual capacities, and through the last two more slowly because of their greater difficulty in bonding. Identification of these phases helps focus primary and secondary preventive therapy for adoptees and families experiencing typical adjustment difficulties and also helps target families in unusual stress. The body of this paper discusses the phases in detail, and then delineates signs of serious disturbances in adjustment to adoptions. A final section provides guidelines for conducting phase-relevant therapy with this population. (RH)

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Critical Phases Among Adoptees and Their Families: Implication for Therapy

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Critical Phases Among Adoptees and their Families:

Implications for Therapy

Abstract

A growing body of literature indicates that families with adopted children seek mental health care for the adoptive and other family members more frequently and for some qualitatively different reasons than families in which all children are biologically-bound to one or both parents (Bohman, 1972; Kadushin, 1980; Maurer, Cadoret & Cain, 1980; Weiss, 1984).

Previous empirical investigations and writings and applied work by the authors indicate that adoptive children pass through several predictable phases toward their personal integration of their adoptive status. The phases of those adopted at or near the time of their birth can be summarized as: preawareness of the adoptive status, cognitive integration of biological and social differences; concomitant acceptance of the biological and adoptive family.

It is posited that older adoptees pass through a similar set of phases; however, they move through the first two phases of cognitive integration at a more rapid rate because of their broader intellectual capacities. Their movement through the last two phases is more protracted because of their greater difficulty bonding due to their age of adoption and previous experiences.

Recognizing the psychological stresses upon the adoptee and his or her family at each stage assists mental health professionals in providing effective preventative and corrective clinical intervention. For example, among many adopted adolescents, extreme narcissistic struggles may emerge that are related to earlier unmet narcissistic needs of infants whose bonding has been disrupted. Therapy aimed at ameliorating narcissistic preoccupation is particularly helpful for this population (Sallee & LeVine, 1986). In a similar and more extensive fashion, this paper addresses the struggles and corrective strategies for adoptive families at various levels of their development.

Critical Phases Among Adoptees and Their Families: Implications for Therapy

Introduction

Each year increasing numbers of children are adopted. In 1987, there will be 125,000 children free for adoption (Grabe, 1986). Another 300,000 to 500,000 children will be in foster care or other out-of-home care (Children's Defense Fund, 1978). Step-parent adoptions will account for another 100,000 adoptions (National Center for Social Statistics, 1975). Furthermore, Public Law 96-272, the Adoption and Child Welfare Act of 1980, charged social services agencies to attempt to place older and special needs foster children into permanent homes. The increasing numbers and types of adoptions has led to greater concern among social service professionals and potential adopting families to learn about the adjustments of adoptive children and their families.

Although the literature about the adjustment needs of the adoptee and his or her family is not extensive, the data available clearly indicate that adjustment to adoption is highly taxing both emotionally and behaviorally for the adopted child and family. Under the most ideal circumstances, the adopted child will experience personal stresses as he or she moves toward integration of the adoptive status. The special adjustment problems of this population are indicated by several sets of data. Firstly,

the results of several studies conducted at mental health facilities point to special adjustment needs of the population. Adopted children constitute one percent of the total population of children, but 4.6 percent of the population of children hospitalized in intake health facilities. Of those adoptive families receiving help, treatment was reported as highly successful in 72% of the cases, moderately successful in 16%, and unsuccessful in 12% of the referrals (Kadushin, 1980). Weiss, (1984) compared the relationship of adoptive and biological children to their parents upon admissions to a psychiatric hospital. Adoptive parents had more trouble relating to their children as indicated by the number of visits they made.

Another index of the difficult nature of adoption is the disruption rate; that is, the percent of cases in which the adopted child is removed from the home and the legal adoption is dissolved. Between the years of 1955 to 1970, the disruption rate was 3.1 percent. In the period of 1968 to 1977, the rate was 10.6 percent (Kadushin, 1980). However, these figures are difficult to compare as more and more older children and severely abused and neglected youths have been placed in adoptive homes in recent years. In another study, the disruption rate of 735 developmentally disabled in the United States and Canada was evaluated. Overall disruption rate was 8.7 percent. If the child was adopted by the foster parents, the rate dropped to 4.4 percent. The age at time of adoption clearly effects

disruption rate. The adoption of developmentally delayed children under the age of seven disrupted at the rate of 3.3 percent while similar adoptees ages eight and older disrupted at a rate of 17.7 percent (Coyne & Brown, 1985). Under the Federal and State funding limits for child welfare services, post placement work appears to be on a decline. Thus, in the future it appears that the disruption rate will continue to rise due to the older ages and special needs of the adoptive children and lack of follow-up service.

A critical factor in analyzing the adjustment of adoptive families is to establish whether difficulties are due to broad problems in the family dynamics or more directly linked to the adoption. In reviewing twenty major studies in the field of adoption, Kadushin (1980) reports that adjustment difficulties are more likely to occur if the parents are older at the time of adoption, if the child is an only child, if the parents or extended family do not firmly support the adoption, and if there is strife in the family. In general, then, research indicates that many family problems, that would have existed whether the child was biological or adopted, become more complex and intense due to the adoption.

The authors' review of empirical investigations and our empirical and clinical work indicate that it is helpful to view adoption from a psychosocial and psychodynamic perspective. Accordingly, the child and family pass through predictable phases in the adoption process that coincide

with family and individual development. Identification of these phases helps focus primary and secondary preventive therapy for adoptees and families experiencing typical adjustment difficulties and also helps target families in unusual stress. The phases, as summarized in Table 1, will be examined in detail below. A further section delineates signs of serious disturbances in adjustment to adoptions. A final section provides guidelines for conducting phase-relevant therapy with this population.

It is the authors' experience that almost all adoptees pass through the various phases in their adjustment to the adoptive home. Most likely, older adoptees of normal or above intelligence pass through the first two phases at a rapid rate because of their broader intellectual capacity. However, movement through the third phase is likely to be protracted for older adoptees because of early trauma and concomitant greater difficulty bonding to their adoptive parents.

Adoption

Phase I: Preawareness

Before age three, most children do not have an awareness of their adoptive status because of the limits of their cognition. However, the typical adoptee is moved two

TABLE 1

PHASES OF ADOPTION ADJUSTMENT

Phase	Typical Psychological Issues	Signs of Severe Maladjustment
I. Preawareness	Overactivity Withdrawal Acting out	Unneutralized aggression Pervasive development disorder
II. Dim awareness of a special state	Talk about feeling different Confusion of past and present home	Poor object relations
III. Cognitive integration of biological and social differences	Oppositionality to adoptive parents Increased questioning about family of origin	Desperate search and desire to be reunited with family of origin
IV. Identity crisis of the adopted adolescent	Active search for family of origin and biological roots	Severe narcissistic and borderline disorders
V. Concomitant acceptance of the biological and adoptive family	Adopted issues reconciled	Feelings about early abuse, neglect and loss not reconciled and manifest as various personal and relationship, and social issues in the adult

and a half times before receiving placement (Grabe, 1986). Even those adopted shortly after birth may experience some adjustment difficulties as they are moved from what is familiar to them before and shortly after birth to their adoptive homes. Therefore, it is not uncommon for adopted babies and toddlers to exhibit some basic adjustment difficulties, bearing from over activity to withdrawal or aggressive acting out.

Phase II: Dim awareness of a special state

Children's first insights about their adoption seem to center upon their recognition that they are somehow different than most other children. At phase II, children do not seem to have a clear understanding that they are not living with biological parents, and they have not started to grapple with the implications of being raised by someone other than their hereditary mother and father. However, they realize that a social agency is somehow involved in their past while such social service in not in the lives of most nonadopted children.

For children adopted shortly after birth, the dim awareness of the special state emerges at about age four. Brodzinski, Singer and Braff (1984) conducted an extensive study of adoptees during the elementary school age years and concluded that by about age four, the adoptee begins to talk of being different, of being special, and of realizing that there are formal agencies, not only biology, associated with

the beginnings of their lives.

Older adoptees, too, begin to focus on their differences. As Grabe (1986) states, they understand that there is significance to their being "children of the system."

There are some common adjustment problems during phase two. Older adoptees may talk about being different than their siblings and may express vague complaints of not feeling loved like other children. Younger adoptees may confuse the names and roles of persons in their past lives with those in their present. Younger children may express concerns at this phase through their play. For example, they may demonstrate their family dynamics with puppets or play houses in which they present themselves as outside the family circle.

Phase III: Cognitive integration of biological and social differences

Gradually, an adoptee learn about his or her distinctiveness in being raised by parents who are not biologically their own. Among children adopted close to birth, Brodzinski, Singer and Braff (1984) report that this awareness emerges around the ages of eight to eleven. Not surprisingly, the age of awareness of their unique biological and social status concurs with the time period in which Piaget (1976) indicates children develop a capacity for higher order or formal logic.

Of course, children adopted at an older age will move rather rapidly from a focus on being different and a product of the system to phase III in which they grapple with their unique biological and social identity in the family.

It is common for children at this stage to begin to express curiosity about their biological parents. There may be regression in their attachment to their adopted families, as indicated by oppositionality and direct questioning of whether they are loved by their adopted parents and by their natural parents.

Phase IV: Personal and identity crisis of the adopted adolescent

Erickson (1968) writes that the components of establishing an identity involve developing: 1) a conscious sense of individual uniqueness; 2) an unconscious striving for continuity of experience; and 3) a solidarity with group ideals. The adopted adolescent will encounter the same stress in establishing a sense of personal identity as do other adolescents. Clearly, the adopted adolescent's striving for continuity with his or her past and solidarity with the group is more difficult than for nonadopted peers.

In a previous article (Sallee & LeVine, 1985) the authors explain that the unique identity crisis faced by an adopted teenager is well illustrated by the story of Narcissus. As a youth, Narcissus fell in love with his own image in a pool of water. He could never grasp the image in

the pool, yet he could not leave. He learned the lesson that energy invested totally in oneself does not lead to a more enduring meaning. Most teenagers tend to be very narcissistic. A teenager must harness dramatic physical, social, and psychological changes within in order to enhance his or her personal development. The changes in teenagers may preoccupy them as they spend many hours before a mirror, preening or grooming themselves. The adolescent faces many societal changes. Few meaningful contributions to society are required of today's teenagers, driving their efforts inward. Teenagers will speak for hours on the phone on rather trivial matters; however, in this society, their chatting is the primary way to learn about their identity. Other activities such as chores around the house pale in comparison to this powerful personal search for identity.

The psychoanalytic literature relates how children are born in almost a totally narcissistic state, with their existence centered on meeting their need for comfort. As these needs are met, newborns quickly learn to reciprocate. They share coos, smiles, and cuddles. So begins a shift from total narcissism to individualism as a social being who enjoys mutuality with the parent. Giving and taking continues throughout the developmental stages until the beginning of adolescence.

We have stated that young adoptees may display selfishness, unreasonable demands and other acting out behaviors. If these behaviors are criticized by adults, the

children may develop narcissistic wounds which reemerge during the identity crisis. Adolescents who were moved many times through the social service system and who experienced abuse and neglect are particularly likely candidates for narcissistic difficulties. A recent review of the literature on abuse and neglect (Steele, 1986) indicates that approximately one half of the patients in psychiatric hospitals and clinics who are diagnosed with narcissistic and borderline disorders report varying degrees of abuse and neglect early in their lives. Even if removal from the biological mother was within the first few weeks of life, a normal attachment may fail to occur because of factors such as differences in temperament and parenting style.

If the process of bonding, attachment and gradual separation from parental figures is disrupted, the movement from total narcissism to the mutuality is blocked. Thus, adopted children who suffered early bonding difficulties may be particularly prone to narcissistic behaviors as teenagers.

Phase V: Concomitant acceptance of the biological and adoptive family

This phase can begin at various ages past the stage of cognitive integration of differences. In some cases in which the transition to the adoptive family begins early and/or progresses smoothly, movement to this phase may occur before the teenage years. In more difficult cases,

acceptance may not fully occur until the adoptee reached adulthood. At whatever age, movement to th this phase clearly heralds a significant accomplishment requiring dedication, honesty and commitment by the adoptee and the family.

We have pointed out that certain personal and emotional issues seems to be characteristic of the adoptees in each phase of their development. Within supportive environments, adoptees will struggle and work through these issues. In other cases, short term preventive counseling facilitates movement to the next phase.

However, at each phase, there are also some emotional and behavioral manifestations that signal more serious and recalcitrant disturbance related to the adoption. The disturbance may be caused by conditions in the experiences which preceded the adoption or conditions in the adoptees present home. Regardless, they are expressed at least in part, through adoption related issues such as feeling attached to adoptive parents and feeling loved. The major issues associated with each phase are explicated in the following section.

Serious Indices of Maladjustment

For children in a preawareness phase, serious indices of maladjustment related to the adoption are most likely demonstrated in youngsters who are products of severe abuse and neglect. The manifestation of this maltreatment fall

under the rubric of pervasive developmental disorders (American Psychiatric Association, 1980). A most common characteristic is unneutralized rage (Cline, 1986). These youngsters may also demonstrate a pathological unresponsiveness to adults, gross deficits in language development, constricted or inappropriate effect, oddities of motion, hyper or hyposensitivity and resistance to change.

Some children with severe difficulties in phase I and from other adopted children, display severe disturbance in phase II, during the time of dim awareness of the special state. Problems at this phase seem to center around an inability to develop good object relations. The children have a tendency to split objects into good and bad rather than to form more realistic perceptions of their biological and adoptive parents. Sometimes children from abused and neglected backgrounds, see their natural parents as totally bad objects, and this precepts creates a sense of fear and separateness from all adults. More often, the child over idealized the lost object and sees the biological parents as the good object while transferring the negative feelings to the adoptive parents.

This struggle is well exemplified by the authors' work with Jonathan from ages five through eight, who was adopted at six months of age following removal from a highly neglectful home. His adjustment from age six months to three years was relatively unremarkable. Starting about age

three, he began expressing deep rage towards himself and others. He talked of mother, father and Jonathan alligators inside his stomach who were eating each other up. One school day, Jonathan flew into an uncontrolled rage. Upon the therapist's recommendation, the teachers placed Jonathan in time out. As he began to calm down, Jonathan was heard repeating the following phrase, "My life is a whirlpool, but my father is safe." In a later play therapy session, Jonathan heard the roar of an airplane overhead and commented that his father flew that plane. The therapist realized that Jonathan usually referred to his male adopted parent as "Daddy." He had used the term "father" in two unusual circumstances. Upon questioning Jonathan, it was learned that he referred to his biological parent as "Father." He knew nothing about his biological parent, but had created a complete, idealized image of him.

Sometimes severe disturbance is associated with movement through the third phase of cognitive integration of biological and social differences. Severe maladjustment at this phase is signaled by an active rejection of the adoptive family and the desperate search to find and be reconnected with the biological parents. Again, critical problems at this stage can be prompted by early trauma or current events in the child's life.

The authors worked with a child whose adoption at age two weeks seemed to progress smoothly until his adoptive

parents separated when he was six years old. Because of the parents' emotional problems, Joshua did not feel fully safe with either one. For two years following his parents' separation and divorce, Joshua longed for their reunion. He was depressed and expressed many psychosomatic symptoms. At age eight, he fell desperately in love with an eighteen year old girl. He pined for her. He began having weeping spells and rejecting his adoptive mother. Finally, he burst forth with a desperate desire to know his biological mother. "I must find her," he cried. "I need to know she's alright. I know she needs me."

In phase IV of the identity crisis of the adopted adolescence, severe disturbance associated with adoption is expressed in the form of character disorders. Some adopted adolescents express excessive narcissistic and borderline traits with the emergence of pubescence. This narcissism is an expression of poor object relations, and thus, a reenactment of earlier trauma. Employing the DSM III (American Psychiatric Association, 1980), the narcissistic personality can be identified by five primary traits. First of all, narcissistic adolescents focus on their own self-importance, at times to grandiose proportions. They exaggerate their talents and their achievements as well as their needs and problems. Secondly, they may be characterized by a constant need for attention, preferring positive attention but settling for negative attention rather than none at all. The need for approval or

admiration cannot seem to be quelled. Thirdly, their emotions swing to extreme proportions so that they often seem isolated and difficult to reach. At one moment, they may express a cold indifference; at the next moment, a feeling of rage, inferiority, shame, humiliation, or emptiness. These swings may be prompted by relatively minor events, since even a minor correction may be perceived as an attack. Fourthly, they may express feelings of entitlement- that is, the expectations of special favors without assuming reciprocal responsibility. Surprise and anger may follow when people do not do what they want or expect. Finally, interpersonal exploitation may become pronounced, so that they seem to be concerned with others only to meet their own advantage. They may try to indulge their desires by rejecting empathy and expressing an unwillingness or inability to recognize what others feel. Other people, especially parents, tend to be seen in absolute terms that alternate between over-idealization and devaluation.

Finally, some children do not reach the fifth stage of concomitant acceptance of the biological and adoptive status. The feelings about early loss, abuse and neglect are not reconciled. A proportion of these cases end in disruption of the adoption. Among all adoptees, up to fifteen percent of adoptions may be disrupted (LeVine and Sallee, 1986). Among older adoptees, the proportion may be as high as twenty-five percent (Grabe, 1986). No doubt a large number of the disrupted adoptions involve children and

families who, despite much effort and support, have been unable to reach the fifth phase in the adoptive process. In other cases, the adoption is sustained in a distressed fashion even though the fifth stage is never reached. In such cases, the adoptee enters adulthood with many unresolved personal issues that lead to their limited empathy, poor social skills and shallow relationships.

Treatment

An essential step in treating adopted children and their families is to make an accurate assessment. The therapist must determine, firstly, if their problems are primarily within the family system or if the major problem is that the adoptee is a "systems child" (Grabe, 1986).

If the primary basis of the problems is within the family system, the therapist's traditional armamentarium will be highly successful. Parent education, supportive therapy with particular individuals in the family system, and systems intervention will all be helpful.

If, however, the focus of the problems is that the adopted child and family are in stress because the child has suffered before the adoption through the adoption process, different tactics are necessary.

The experts on adoption agree that supported therapy aimed strictly for the child seldom works with the "systems" child. It is crucial that the family receives support so

that they do not feel left out or blamed for the child's problems which started previous to their parenting and are often quite severe and recalcitrant. When the therapist neglects the righteous pain of these families and forms a private alliance with the child, the family is quite likely to drop out of therapy, feeling misunderstood and blamed (Grabe, 1986).

Secondly, the family that struggles with the "systems child" needs techniques for quick behavioral redress. The family often seeks therapy in acute distress. The parents chose to adopt a child for intense reasons, for example, because they could have no children of their own or because they wanted to reach out to one less fortune than themselves. They come to therapy with their cherished dreams shattered. Teaching behavioral strategies for managing the child's behavior, and at times, finding short term placement for the child may be necessary to bring anxiety and disappointment to a manageable level so that therapy can proceed.

Once the most severe acting out is ameliorated, the therapist needs to make a finer differentiation in diagnosis. Our work has shown that it is important to determine if the systems child and the adoptive family are suffering from problems that can be considered relatively typical reactions through the phases of adoption, or whether the signs of serious maladjustment to the adoption are present. This distinction between typical and severe

reactions to adoptions was drawn earlier in this paper under the section in which the phases of adoption were discussed. One could also view the differentiation in terms of distinguishing children with neurotic symptomology whose object relations are skewed from those children whose problem are more characterological and who, therefore, have not internalized parental objects (Cline, 1986).

If the therapist determines that the problems fall within the typical range of reactions to adoption, a variety of primary and secondary prevention methods can be helpful. Group therapy for the children may be productive. The National Region #2 Adoption Resource Center developed a program of six sessions in which children are taught to express their views about themselves and their lives:

Who am I?

Who am I in the family?

How do I feel about it?

Who am I in the system?

Who am I going to be?

Ongoing therapy for parents is also helpful. Western Pennsylvania Parent and Adoption Children's Organization developed an interesting parent model in which the families meet in an ongoing fashion with a therapist who stays involved with the families over a number of years.

A number of techniques have been developed to help adoptive children work through their grief reactions about past losses. Holding procedures and a candle light ceremony

have been reported as quite helpful (Anderson, 1986). Anderson (1986) explains that grief reaction cannot be resolved as the loss of a biological parent will not go away. However, specialized techniques will help the child and adoptive family reconcile emotions so that child and family can reappraise what they can expect from one another and come to accept what they can give each other.

Other techniques, such as the Life Book can help the child formulate a clearer identity. In 1981, a New York State project showed that inside oriented preventive therapy also aided the child in moving through the phases of adoption. Spaulding for Children published a life book kit entitled "Here I Am" for use with adopted developmentally disabled children (Schroen, 1984).

If the disturbance is more characterological and narcissistic, the process of treatment is very complex. Of course, the exact treatment will depend upon the adoptee's unique profile and the clinician's persuasion. As a whole, long term and insight-oriented therapy for the adoptee is recommended. Adler (1986) summarizes well the basic themes that will emerge in interpretive therapy:

1. rage toward the attachment figures that were not available earlier
2. desire to possess and encompass the present parent figures
3. tendencies to see attachment figures in grandios terms
4. disappointment when the adoptive parents fail at perfect mirroring.

In cases of severe characterological disorder, parents need much support. At a minimum they need education to understand the child's disorder and to not hold themselves responsible for the errors of the biological parents and/or the social system. The parents also need realistic feedback about what they can expect, that with some low level narcissistic functioning adolescents with many borderline features full amelioration of symptomology in attachment may not be possible. Supportive therapy may lead to symptomatic relief for these adolescents but little overall change in ways of relating and attaching. Thus, the parents need direct information about:

1. what they can expect of the child
2. what part, if any, of the problems they are responsible for
3. what they can change.

Of course, in the most severe cases, it is appropriate to look for an alternative living arrangement that allows the adopted child some contact with the adoptive parents without demanding ongoing intimacy which triggers deep narcissistic wounds and defenses. Thus, for example, some severely characterological adopted adolescents can be moved to a highly structured foster home or group home during the week and maintain successful relationships with parents on weekends.

In summary, treatment of adoptive children and their families necessitates recognition of the special stresses

these families incur. Because adjustment to adoption is highly complex and always in flux, preventative therapy in the form of support groups for children and parents which are reinstituted at various stages in the family's development is highly recommended. Treatment of adopted children with severe behavioral or emotional problems requires careful evaluation based upon our understanding of the special strains associated with adoption. The use of special techniques designed for the diagnosis and treatment of the adoptee's and family's needs at various stages of the adoption can enhance assistance to these special families in search of mental health intervention.

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